AIA

CONFIDENTIAL MEDICAL CERTIFICATE－醫生報告

PART II - To be completed by doctor at Insured's / Claimant's expense 第二部份（受保人或申請人自費由主診醫生填寫)

Policy Number 保單號碼	
Name of Insured 受保人姓名	ID Card / Passport No. 身分證 / 護照號碼

FEMALE PRODUCT－女性保險

New Born Baby Congenital Anomaly 新生嬰兒先天性異常－TETRALOGY OF FALLOT 法樂氏四聯症

Tetralogy of Fallot shall mean a congenital anatomic abnormality producing progressive cyanosis from infancy as a result of the presence of a combination of pulmonary stenosis, a ventricular septal defect, right ventricular hypertrophy, and dextroposition of the aorta. Such a diagnosis must be confirmed by an appropriate physician by cardiac catheterization, angiocardiography, or by echocardiography. Variants without the classical combination of all the above anatomical abnormalities are excluded.

「**法樂氏四聯症**」是指一種先天性的結構異常，包括肺動脈狹窄、心室間隔缺損、右心室肥大及主動脈向右移位，導致自嬰兒時期開始的漸進紫紺。有關診斷必需獲合資格的醫生以心導管檢查、心血管造影術或超聲心動圖確認。沒有包括上述的典型組合的任何變種，均不包括在此項先天性異常的定義內。

1. Are you the Insured's usual medical physician?
   閣下是否受保人慣常求診之醫生？ ☐ Yes 是 ☐ No 否

   If "yes", when did the Insured first consult you? 如"是"，請問受保人首次向閣下求診之日期？

   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

   If "no", do you know who is her usual medical physician? 如"否"，請問受保人慣常求診之醫生是誰？

2. When were you first consulted for this illness?
   受保人首次就有關疾病向閣下求診之日期。

   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

3. Is there anything in the Insured's family history which would have increased the risk of this illness?
   受保人之家族病史是否增加受保人患上此病之機會？ ☐ Yes 是 ☐ No 否

4. Other physicians or medical facilities the patient has consulted for this condition.
   受保人曾經就診之其他醫生或醫療機構資料。

Name of physician / facility 醫生 / 機構名稱	Address 地址	Date of consultation / confinement period 求診日期 / 住院時段

5. How long has the condition been medically documented? 上述病症約存在了多久？

6. When was the diagnosis made? Please state the date. 診斷是何時被確認？請列出日期。

Details of "Yes" answers (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).
如答"是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機構名稱及地址等資料。

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DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

7. Is there severe or total right ventricular outflow tract obstruction? Please elaborate.
右心室外流之血管是否有嚴重或完全阻塞之情況? 請詳述。

8 Is there ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly? Please elaborate. 是否有心室間隔缺損而導致靜脈血不經過肺動脈而直接進入主動脈之情況? 請詳述。

9. Please provide dates and details of any operations performed. 請提供接受手術之日期及詳情。

10. Diagnostic tools e.g. cardiac catheterization, angiocardiography or echocardiography, including dates & results. (Please provide copies of reports for reference.) 確實有關診斷的檢驗詳情，如心導管檢查、心血管造影術或超聲心動圖，包括日期及結果。（請提供報告副本以供參考。）

11. Present condition of the insured. 受保人現時之病況。

12 Prognosis. 病情進展：

13. Please state if the Insured has suffered/been treated for any other major illness(es) in the past.
請列明受保人曾患上或接受治療的其他主要疾病。

14. Is there any further information which in your opinion will assist us in assessing this claim? 請提供其他有助審核本索償個案之資料。

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該聲明的符合相關守則及法規之最新版本可於以上網址下載及可供索取。

Name of doctor and qualification 醫生姓名及醫學資格

Signature and official chop 簽署及蓋印

Address and telephone number 地址及聯絡電話

Date 日期

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